STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted 3/2/20-3/5/20. The facility was found in compliance of the requirements CFR 483.73. Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 3/2/20-3/5/20., 2 of 21 complaint allegations was susbstantiated with deficiencies F561 and F947. Event ID#5H0311.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		4/2/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/26/2020

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to provide showers as scheduled for 2 of 2 sampled residents reviewed for choices (Resident # 121 & #128). Findings included: 1. Resident #121 was admitted to the facility on 7/28/17 with multiple diagnoses including bilateral below the knee amputation. The annual Minimum Data Set (MDS) assessment dated 10/8/19 revealed under preferences that it was very important for her to choose between a tub bath, shower, bed bath or sponge bath. The quarterly MDS assessment dated 1/29/20 revealed that Resident #121's cognition was intact, and she was totally dependent for bathing. The assessment further indicated that the resident had no behavior of rejection of care. Review of Resident #121's care plan that was last reviewed on 1/29/20 revealed that the resident required staff assistance to complete activities of daily living (ADL) tasks daily due to BKA. The goal was resident's ADL needs to be met daily. The approaches included to anticipate and to meet resident's needs and to provide bath with one- person assist. Review of the facility's shower schedule revealed that Resident #121 was scheduled to have a shower every Tuesday, Thursday and Saturday on PM shift.	F 561	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #121 is scheduled for showers on Mon-Wed-Fri (7a-7p). Resident #121 has received showers on March 25, 2020. Documented refusal on 3/16 and 3/18 2020. Residents #128 is scheduled for showers on Mon-Wed-Fri (7a-7p) . Resident #128 has received showers on March 25, 2020. Documented refusal on 3/16 and 3/18 2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All facility residents have the potential to be affected by the alleged deficient practice. The Unit managers completed a shower/bath audit for all current residents on 3/18/2020, to validate that residents were scheduled for showers/baths per resident preference and showers/baths were completed for residents on scheduled days. All current residents have received showers/baths as scheduled and requested. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 561	Continued From page 2 The monthly resident council minutes were reviewed. The January 23, 2020 minutes listed a concern about showers not provided consistently. The facility's response was to put a shower team in place to provide showers. During the resident council meeting on 3/4/20 at 2:30 PM, residents were still complaining that showers were not provided as scheduled including Resident #121. On 3/5/20 at 9:04 AM, Resident #121 was interviewed. She stated that concern with showers not provided as scheduled had been discussed in the resident council meeting. She reported that her shower schedule was every Tuesday, Thursday and Saturday in the afternoon shift, and she would prefer to have a shower 3 times a week. When she mentioned about shower to the staff, she would get a bed bath instead. On 3/5/20 at 4:15 PM, the Scheduler was interviewed. She stated that the facility had set up a shower team a month ago, but the NAs assigned to do showers were part time employees and when they worked most of the time they were assigned to work on the floor. When asked for shower documentation for Resident #121 for the last 3 months, the Scheduler provided 1 shower documentation dated 2/6/20. On 3/5/20 at 4:30 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected residents to receive shower as scheduled. She reported that the shower team was put in place a month ago due to concerns from the resident council that showers were not provided as scheduled. The NAs	F 561	recur; Shower/bath schedules are assigned to each resident and the licensed nurse will discuss the schedule with the resident and/or the resident representative to assure choice of shower/bath and scheduled time are according to their wishes. The certified nursing assistant (CNA) will be made aware of scheduled shower/bath day and time using the resident shower list and/or resident Kardex. If the resident refuses the shower/bath, the CNA will document refusal and notify the licensed nurse regarding the refusal. The licensed nurse will validate the refusal and notify resident representative if appropriate and will document the refusal in the progress notes or medication administration record (MAR). The licensed nurse (LN) will review with the resident and/or their representative their shower/bath preferences upon admission, quarterly and significant change and will update the shower/bath schedule according to the resident and/or resident representatives wishes. The DON, ADON and Unit Managers provided education for the nursing staff on3/16 & 3/20, regarding providing showers/baths according to the resident wishes and documentation of shower/bath or documentation of refusals and notification of resident representative when necessary. Indicate how the facility plans to monitor its performance to make sure that	

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F 561	Continued From page 3 assigned to the shower team were part time employees. She was aware that most of the time, they were assigned to work on the floor. 2. Resident #128 was admitted to the facility on 3/8/18 with multiple diagnoses including Congestive Heart Failure (CHF). The annual Minimum Data Set (MDS) assessment dated 10/8/19 revealed under preferences that it was somewhat important for him to choose between a tub bath, shower, bed bath or sponge bath. The quarterly MDS assessment dated 2/4/20 revealed that Resident #128's cognition was "not assessed" and he was totally dependent for bathing. The assessment further indicated that the resident had no behavior of rejection of care. A nurse's note dated 1/16/20 at 8:01 PM indicated that Resident #128 was alert and was able to make his needs known. Review of Resident #128's care plan that was last reviewed on 2/4/20 revealed that the resident had activity of daily living (ADL) self-care deficit related to hemiplegia. The goal was for the resident to maintain his current level of function in his abilities to perform ADLs. The approaches included staff assistance with bathing/showering as necessary. Review of the facility's shower schedule revealed that Resident #128 was scheduled to have a shower every Tuesday, Thursday and Saturday on AM shift. The monthly resident council minutes were reviewed. The January 23, 2020 minutes listed a	F 561	solutions are sustained; The Unit Managers will review shower/bath documentation daily 5 times/week for four weeks then 3 times a week for 2 months. The Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) will review admission assessment documentation and quarterly care plan documentation regarding shower/bath preference 5 times a week for 4 weeks then 3 times a week for 2 months to validate that shower/bath preferences are documented according to the resident and/or resident representative wishes. The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue according to the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2, 2020	

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F 561	Continued From page 4	F 561		

concern about showers not provided consistently. The facility's response was to put a shower team in place to provide showers. During the resident council meeting on 3/4/20 at 2:30 PM, residents were still complaining that showers were not provided as scheduled including Resident #128.

On 3/5/20 at 9:25 AM, Resident #128 was interviewed. He stated that concern with showers not provided as scheduled had been discussed in the resident council meeting. He reported that his shower schedule was every Tuesday, Thursday and Saturday on day shift, and he would prefer to have a shower 3 times a week. Resident #128 revealed that he was not offered shower as scheduled.

On 3/5/20 at 4:15 PM, the Scheduler was interviewed. She stated that the facility had set up a shower team a month ago, but the NAs assigned to do showers were part time employees and when they worked most of the time they were assigned to work on the floor. When asked for shower documentation for the last 3 months for Resident #128, the Scheduler provided 2 shower documentation dated 1/28/20 and 2/12/20.

On 3/5/20 at 4:30 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected residents to receive shower as scheduled. She reported that the shower team was put in place a month ago due to concerns from the resident council that showers were not provided as scheduled. The NAs assigned to the shower team were part time employees. She was aware that most of the time, they were assigned to work on the floor.

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F 584	Continued From page 5	F 584		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		4/2/20

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F 584	Continued From page 6 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to replace a mattress that was ripped in the center and failed to provide a mattress that fit the bed size for 2 of 2 residents (Resident # 61 and Resident # 123) reviewed for a safe and clean homelike environment. Findings included: 1.Resident # 61 was admitted to the facility on 7/11/14 with multiple diagnoses that included dementia, Alzheimer's disease, major depression disorder and adult failure to thrive. The quarterly Minimum Data Set (MDS) dated 1/8/20 revealed, Resident # 61 was cognitively impaired. Resident # 61 was coded as totally dependent on two-person assistance for activities of daily living. Resident was bowel and bladder incontinent. Observation of Resident # 61's bed on 3/03/20 at 10:04 AM, revealed the mattress was ripped and torn in the center. During an interview on 3/03/20 at 10:04 AM, Resident # 61's family member indicated that the resident's mattress was ripped and was not replaced by staff. Observation on 3/04/20 at 8:25 AM revealed Resident # 61 sitting in his Geri chair in the hallway. Observation of the Resident 61's bed in	F 584	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The maintenance director replaced the mattress for Resident #61 on March 4, 2020. The maintenance director replaced the mattress and bed for Resident # 123 on March 4, 2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Maintenance director and Housekeeping supervisor completed a 100% bed and mattress audit 3/6 & 3/10 2020, to identify beds that were not the right size for the resident/mattress and identify torn/worn mattresses. There were no beds that needed to be replaced and mattresses identified that needed replacement began on March 4, 2020 and will completed by April 2, 2020. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Nursing staff and housekeeping staff were educated by Maintenance Director and Assistant Director of Nursing (ADON) on	

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F 584	Continued From page 7 his room revealed the mattress was ripped in the center. Observation on 3/4/20 at 11:27 AM revealed the housekeeping staff were cleaning the resident's bed and mattress. The housekeeping staff #1 was interviewed. Housekeeping staff #1 indicated the bed and mattress were deep cleaned frequently. She indicated if the mattress was ripped, she would inform her manager and replace it. Stated she had just noticed the mattress was ripped. During an interview on 3/4/20 at 11:35 AM, the housekeeping manager stated the resident's beds and mattress were cleaned monthly and as needed. She was not aware the Resident 61's mattress was torn or ripped. She stated the nurse aides (NA) were responsible for making resident's beds and should notify housekeeping if any mattress was torn or needed to be replaced. She further stated if the housekeeping staff noticed any mattress torn or ripped during their deep cleaning, it should be replaced immediately. She confirmed that there were adequate mattresses in the storage to replace. During an interview on 3/4/20 at 11:45 AM, NA # 11 stated she usually made Resident # 61's bed after breakfast. She indicated she had not noticed the mattress was ripped. NA # 11 stated she was unsure how to place a work order for bed mattress replacement. During an interview on 3/4/20 at 11:50 AM, Nurse # 9 stated she was the nurse supervisor for the hallway, where Resident #61 was resided. She stated any staff could place the bed mattress replacement work orders for the maintenance or	F 584	3/36/2020 regarding use of TELs to notify housekeeping and/or maintenance staff when a mattress or bed should be replaced or repaired. Newly hired staff will be educated during new hire orientation. When a staff member identifies a bed that is broken or not the right size for a resident or the mattress is worn or torn, they are to place a work order into the TELs program and/or notify their supervisor. When the work order is received the maintenance director/assistant or housekeeping supervisor will make necessary changes to the bed and/or provide another mattress. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Maintenance director and/or the Housekeeping supervisor will audit 20 beds/mattresses per week for 4 weeks then 40 beds/mattresses per month for 2 months to identify/validate that beds are the right fit and mattresses are not worn/torn. The Maintenance director and/or the Housekeeping supervisor will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Maintenance director and/or the Housekeeping supervisor will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of QAPI committee.	

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F 584	Continued From page 8	F 584		

housekeeping on the computer using the program "TELS". She stated the work orders would go directly to the assigned department. Based on the type of work order placed, the priority of the work order was set. She further stated she could assist any staff in placing the work orders. Nurse # 9 confirmed she was unaware of the mattress being ripped and has not received any request for a bed mattress replacement.

2. Resident # 123 was admitted to the facility on 7/21/14 with multiple diagnoses that included hemiplegia and hemiparesis following cerebrovascular disease affecting the right domain, cirrhosis of liver and liver cell carcinoma.

The quarterly Minimum Data Set (MDS) dated 1/8/20 revealed, Resident # 123 was cognitively intact. Resident # 61 was coded as independent for activities of daily living except for dressing and toilet use were resident needed one-person supervision. Resident was bowel and bladder incontinent.

On 3/2/20 at 8:00 PM, during the observation and interview, Resident #123 was observed lying in bed, well dressed and groomed. The bed mattress was shorter than the bed length. The resident's legs did not reach the gap between mattress and foot board. The resident indicated that he was comfortable on his bed mattress and did not have any issue.

During an interview on 3/4/20 at 11:40 AM, the maintenance director indicated the bed was too big for the resident and the mattress was small for the bed. He indicated the bed needed to be replaced with the size appropriate for the

Indicate dates when corrective action will be completed;
April 2, 2020

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F 584	Continued From page 9 resident. The maintenance director stated the nursing staff were responsible to place a work order on the computer, so that the maintenance staff could fix the issue. He indicated he was not aware that the bed was not the correct size for the resident. During an interview on 3/4/20 at 11:45 AM, NA # 11 stated Resident # 123 was cognitively intact and was independent with activities of daily living. NA # 11 stated the resident usually made his own bed. NA # 11 confirmed that the bed linens were changed weekly and as needed by her. NA # 11 stated she had not noticed the mattress was small for the length of the bed. During an interview on 3/4/20 at 11:50 AM, Nurse # 9 stated she was the nurse supervisor for the hallway, where Resident #123 was resided. She stated any staff could place the bed mattress replacement work orders for the maintenance or housekeeping on the computer using the program "TELS". She stated the work orders would go directly to the assigned department. Based on the type of work order placed, the priority of the work order was set. She further stated she could assist any staff in placing the work orders. Nurse # 9 confirmed she was unaware of the bed was too big for the resident. During an interview on 3/05/20 at 4:29 PM, the administrator stated the staff should notify the maintenance or housekeeping department about any issues related to residents' rooms. The administrator further stated that all staff had access to place a work order in the system.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		4/2/20

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F 636	Continued From page 10	F 636		

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication

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F 636	Continued From page 11 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess the residents in the areas of cognition and mood for 3 of 35 sampled residents reviewed (Residents # 109, #126 & # 128). Findings included: 1. Resident # 109 was originally admitted to the facility on 10/24/19 and was readmitted on 1/21/20 with multiple diagnoses including cerebral palsy and contracture of left and right elbow and hand. The quarterly Minimum Data Set (MDS) assessment dated 1/24/20 revealed that sections C (cognition) and section D (mood) were not assessed.	F 636	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; A modified MDS was opened on 3/23/2020, for Resident # 109. The Social Worker completed sections C & D. The modified MDS was locked and submitted by the MDS coordinator on 3/23/2020. A modified MDS was opened on 3/23/2020, for Resident # 126, the Social worker completed sections C & D. The modified MDS was locked and submitted by the MDS coordinator on 3/23/2020. A modified MDS was opened on3/23/2020, for resident #128, the social worker completed sections C & D. The	

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F 636	Continued From page 12 The nurse's note dated 1/21/20 at 3:36 AM indicated that Resident #109 was readmitted back to the facility and was alert and verbal. On 3/4/20 at 1:10 PM, Social Worker #1 was interviewed. The SW stated that she was responsible for completing sections C and D of the MDS. She indicated that she could not find any documentation as to why she did not complete sections C and D. She further reported that she normally writes a note as to why the interview was not completed but she did not for Resident #109. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the SW was responsible for the completion of sections C and D and she expected the SW to complete these sections by interviewing the resident. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected the MDS assessment to be completed including sections C and D. 2. Resident #126 was admitted to the facility on 1/27/20 with multiple diagnoses including end stage renal disease (ESRD). The admission Minimum Data Set (MDS) assessment dated 2/3/20 was reviewed and revealed that sections C (cognition) and section D (mood) were "not assessed". A nurse's note dated 3/3/20 at 3:07 PM revealed that Resident #126 was alert and verbally responsive. On 3/4/20 at 1:10 PM, Social Worker #1 was	F 636	modified MDS was locked and submitted by the MDS coordinator on 3/23/2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The MDS coordinator completed an audit on 3/24-3/25 2020 of MDS assessments completed through 12/1/2019-3/23/2020. There were 2 additional assessments noted, which have been corrected and transmitted as of 3/25/2020. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The MDS coordinator provided education on 3/23/2020, for the Social Workers, regarding completion of Sections C & D according the RAI manual. Newly hired social workers will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The MDS coordinator will audit all assessments completed 5 times a week for 4 weeks then 3 times a week for 2 months, to validate that sections C & D were not coded not assessed unless it met the RAI manual criteria. The MDS coordinator will review audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The MDS coordinator will review the plan	

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F 636	Continued From page 13 interviewed. The SW stated that she was responsible for completing sections C and D of the MDS. She indicated that her documentation revealed that she went to Resident #126's room to assess the resident and she was informed that the resident was out of the facility and so she coded sections C and D as "not assessed". On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the SW was responsible for the completion of sections C and D and she expected the SW to complete these sections by interviewing the resident. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected the MDS assessment to be completed including sections C and D. 3. Resident #128 was admitted to the facility on 3/8/18 with multiple diagnoses including Depression. The quarterly Minimum Data Set (MDS) assessment dated 2/4/20 was reviewed and revealed that sections C (cognition) and section D (mood) were "not assessed". A nurse's note dated 1/16/20 at 8:01 PM indicated that Resident #128 was alert and was able to make his needs known. On 3/5/20 at 10:20 AM, Social Worker #1 was interviewed. The SW stated that she was responsible for completing sections C and D of the MDS. She reported that the MDS Nurse had added Resident #128 on the list of MDS to be completed and she did not have the time to complete sections C and D, and so she coded the sections as "not assessed".	F 636	during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2, 2020	

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F 636	Continued From page 14 On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the SW was responsible for the completion of sections C and D and she expected the SW to complete these sections by interviewing the resident. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected the MDS assessment to be completed including sections C and D.	F 636		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		4/2/20

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(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an

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F 645	Continued From page 16 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident with diagnoses of mental illness for a Pre-admission Screening and Resident Review (PASARR) Level 11 screen for 1 of 4 sampled residents reviewed for PASARR (Resident #126). Findings included: Resident #126 was admitted to the facility on 1/27/20 with multiple diagnoses including hallucination, delusional disorder, post-traumatic stress disorder and psychosis. Resident #126 was admitted to the facility with PASARR level 1 screen dated 2015. The doctor's progress note on admission dated 1/28/20 revealed that Resident #126 was sent o the hospital on 12/23/19 for acute agitation secondary to a sensation he had bugs crawling on his skin. He was ruled out for acute infection and was admitted to the geri-psych unit with gabapantine (used to treat nerve pain) and olanzapine (an anti-psychotic drug). The note further stated that the resident was status post hospitalization for acute delusional parasitosis/disorder. He was stable and to continue Olanzapine and to place referral to psych. Resident #126's admission care plan problem revealed that the resident was on psychotropic medications related to history of hallucinations	F 645	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 126 was discharged to hospital on 3/3/2020 and has not returned to the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Unit managers completed an audit on 3/9-3/13 2020 of current facility residents with a mental illness diagnosis and/or receiving an antipsychotic medication, to validate that a PASARR Level II screening had been completed. The were a total of # 9 residents identified and the PASARR was submitted for Level II review on 3/24-3/25 2020. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; When a resident is admitted to the facility, the hospital will provide the facility with an updated PASARR screen. The Admission Director will obtain the PASSAR with the hospital discharging information. The Admission Director will provide a copy of the PASSAR to the MDS coordinator and the Social Worker. The Unit coordinators will review physician	

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F 645	Continued From page 17 (that bugs were crawling over his skin). The approaches included to administer the psychotropic medications as ordered. Resident #126's doctor's orders were reviewed. On 1/27/20 (admission), the resident had an order for Olanzapine 7.5 milligrams (mgs) 1 tablet by mouth at bedtime for delusional disorder. On 2/3/20, there was a doctor's order to increase the Olanzapine to 15 mgs 1 tablet by mouth at bedtime for psychosis. Review of the admission Minimum Data Set (MDS) assessment dated 2/3/20 revealed that Resident #126 was not referred to the state for a Level 11 PASARR screening. On 3/4/20 at 11:13 AM, Social Worker #1 was interviewed. She stated that she was responsible for submitting information to the state for PASARR screening. The SW verified that Resident #126 had a level 1 PASARR on admission and she was aware that the resident had diagnoses of mental illness on admission. She further indicated that she did not refer Resident #126 to the state for PASARR level 11 screening since the resident was stable and had no behaviors. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she was not familiar of the regulations regarding PASARR screening, but she expected the social worker to follow the regulations regarding referral of residents for PASARR level 11 screening. On 3/5/20 at 4:01 PM, the Administrator was interviewed. She stated that she expected the	F 645	telephone orders 5 times a week to identify orders for antipsychotic medications and/or diagnosis of mental illness/intellectual disability. The Unit coordinator will notify the Social worker and the Social Worker will submit a new PASSAR screening to the state for review for Level II. If a PASSAR Level II is received, the SW will notify the MDS coordinator to ensure accurate coding of the MDS assessments. The Administrator and the Director of Nursing (DON) provided education on 3/26/2020, to the Admission coordinator, Social workers, MDS coordinators and unit managers regarding the facility process for identifying residents that receive an antipsychotic medication and/or a diagnosis of mental illness/intellectual disability. When a resident has orders for an antipsychotic medication or diagnosis of a mental illness/intellectual disability, the Social Worker will submit a PASSAR screen to the state to be reviewed for Level II. If a PASSAR Level II is received, the SW will notify the MDS coordinator to ensure accurate coding of the MDS assessments Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will audit physician telephone orders 5 x week for 4 weeks then 3 times a week for 2 months to identify orders for an antipsychotic medication and/or diagnosis of mental illness/intellectual disability and	

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F 645	Continued From page 18 regulations regarding PASARR screening to be followed.	F 645	will validate that the information was communicated to the Social worker when medication/diagnosis were identified and the SW submitted a PASSAR Level II screening. The DON or ADON will review the audits monthly to identify patterns/trends monthly and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2, 2020	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		4/2/20

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F 656	Continued From page 19 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan for nutrition for 2 of 5 sampled resident reviewed for nutrition (Residents #19 & #24). Findings included: 1. Resident #19 was admitted to the facility on 12/4/19 with multiple diagnoses including glaucoma. The modification admission Minimum Data Set (MDS) assessment dated 12/16/19 revealed that Resident #19 had severe cognitive impairment and she needed extensive assistance with eating.	F 656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Registered Dietician completed a nutrition care plan for Resident #19 on March 5, 2020. The Registered Dietician completed a nutrition care plan for Resident #24 on March 5, 2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Registered Dietician completed an	

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F 656	Continued From page 20 On 12/4/19, Resident #19 had a doctor's order for mechanical soft diet with thin liquids and on 2/4/20, the diet was changed to mechanical soft with nectar thick liquids. The care area assessment (CAA) dated 12/26/19 revealed that nutrition was triggered due to elevated body mass index (BMI). Her BMI was above normal at 28%. Her weight, BMI and other nutritional needs were monitored by the facility's dietician with assistance from the rest of the interdisciplinary team (IDT). Will proceed to care plan. Review of Resident #19's care plan revealed that there was no care plan developed for nutrition. Resident #19's weight on admission (12/4/19) was 159 pounds (lbs.) and was 150 lbs. on 2/4/20. On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the Dietary Manager (DM) was responsible for developing the care plan for nutrition. She verified that she had checked Resident #19's care plan and there was no care plan developed for nutrition. The MDS Nurse further stated that Resident #19 should have a care plan developed for nutrition due to the presence of pressure ulcer, potential for weight loss and she was on therapeutic diet. On 3/4/20 at 4:33 PM, the Dietary Manager (DM) was interviewed. He stated that he was responsible for developing the care plan for nutrition. The DM reviewed the resident's care plan and verified that there was no care plan for nutrition and he stated that he did not know why it	F 656	audit on 3/5/2020, of current residents most recently completed Care Area Assessment (CAA), to identify residents that had triggered nutrition and validated that a nutrition care plan had been implemented. There were no other residents identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The MDS coordinator and Registered Dietician provided education on 3/25/2020 for the Dietary manager regarding completion of nutrition care plan when a CAA was triggered. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The MDS coordinator will audit triggered nutrition CAAS that are completed weekly for 4 weeks then every 2 weeks for 2 months, to validate that a nutrition care plan was implemented. The MDS coordinator will review the audits monthly to identify any patterns/trends and will adjust the plan as necessary to maintain compliance. The MDS coordinator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2, 2020	

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was missed.

On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she expected a care plan for nutrition developed for Resident #19.

2. Resident #24 was admitted to the facility on 5/20/19 with multiple diagnoses that included Dementia, Encephalopathy, and Chronic kidney disease (stage 3). The quarterly Minimum Data Set (MDS) assessment dated 12/17/19 revealed that Resident #24 had severe cognitive impairment and needed extensive assistance with eating.

Review of the physician orders revealed Resident #24 was on mechanical soft diet with thin liquids and on nutrition supplement twice a day for low Body Mass Index (BMI).

The care area assessment (CAA) dated 5/27/19 revealed that nutrition was triggered due to low BMI of 16.212. Will proceed to care plan.

Review of Resident #24's care plan revealed that there was no care plan developed for nutrition.

Resident #24's weight on 12/9/19 was 122 pounds (lbs.) and on 2/21/20 was 116 lbs. A 4.67% weight loss in 3 months.

On 3/4/20 at 3:28 PM, the MDS Coordinator was interviewed. The MDS Coordinator stated that the Dietary department was responsible for developing the care plan for nutrition. She verified that she had checked Resident #24's care plan and there was no care plan developed for

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F 656	Continued From page 22 nutrition. On 3/4/20 at 4:33 PM, the dietary staff was interviewed. He stated he was a certified dietary manager and both he and the dietitian were responsible for developing the resident's nutrition care plan. He reviewed Resident # 24's care plan and verified that there was no care plan for nutrition, and that the care plan was missed. During an interview on 3/5/20 at 3:28 PM, the dietitian stated the resident was triggered for nutrition care plan based on the CAA, which indicated a low BMI. The dietitian confirmed that the resident's nutrition care plan was missed. During an interview on 3/5/20 at 4:29 PM, the Administrator stated all care plans for residents should be completed on time, especially when CAA's were triggered for an area.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		4/2/20

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F 688	Continued From page 23 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide range of motion (ROM) exercises and to apply the splints consistently as ordered for 2 of 2 sampled residents reviewed for range of motion (Residents # 109 & #25). Findings included: 1. Resident # 109 was originally admitted to the facility on 10/24/19 and was readmitted on 1/21/20 with multiple diagnoses including cerebral palsy and contracture of left and right elbow and hand. The quarterly Minimum Data Set (MDS) assessment dated 1/24/20 revealed that the resident had limitation in ROM on both upper and lower extremities and was not on restorative nursing program. Resident #109 was evaluated and treated by the Occupational therapist (OT) for management of right and left elbow/hand contractures on 1/22/20. On 1/28/20, OT had discontinued treating Resident #109 and had recommended ROM exercises and splint application to right and left elbow for 4-5 hours in order to prevent decline. The OT note dated 1/28/20 indicated that the staff were educated and demonstrated competency with bilateral upper extremity (BUE) splint wear schedule and proper application of splint and perform skin checks post splint application. Resident #109's care plan last reviewed on 1/24/20 revealed a problem "resident has	F 688	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #109 was screened by the Occupational therapist (OT) on 3/24/2020, to review current Range of Motion (ROM) and splinting orders and current orders remain appropriate ROM and splinting orders were written on the Functional Maintenance Program documentation (grid) form on 3/26/2020 for documentation to be completed by the Certified Nursing Assistant (CNA) beginning on 3/27/2020. Resident #25 was screened, evaluated and treated by the Occupational therapist (OT) on 3/12/2020 to review current splinting orders and is currently receiving treatment for contracture management. Resident will remain on therapy caseload until 4/1/2020 at which time new orders will be implemented. Splinting orders will be written on the Functional Maintenance Program documentation grid form on 4/1/2020 for the documentation to be completed by the Certified Nursing Assistant (CNA) beginning on 4/2/2020 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Assistant Director of Nursing (ADON) and Unit Coordinators completed an audit	

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F 688	Continued From page 24 cerebral palsy affecting his bilateral upper and lower extremities". The goal was "the resident will be able to function at the fullest potential possible as outlined by the treatment plan". The approaches included maintain good body alignment to prevent worsening of contractures and to use braces and splints as ordered". Resident #109 had a doctor's order dated 2/4/20 for staff to perform BUE ROM exercises 2 sets of 10 repetitions (reps) then do elbow extension splint to one upper extremity at a time with resident to wear splint for 4 - 6 hours per day 7 times a week and for the staff to perform skin checks upon splint removal. The Treatment Administration Records (TARs) for February and March 2020 were reviewed. The TARs listed the order for the staff to perform the BUE ROM exercises and the splint application to be provided during the 7-3 shift. The February 2020 TAR revealed that the ROM exercises and the splint application were not provided for 14 days (2/5, 2/6, 2/7, 2/13, 2/17, 2/18, 2/19, 2/20, 2/21, 2/24, 2/25, 2/26, 2/27, and 2/28). The March 2020 TAR revealed that the ROM exercises and the splint application were not provided on 3/2, 3/4 and 3/5. On 3/2/20 at 7:30 PM, Resident #109 was observed in bed. His upper extremities were observed to be contracted and there was no splint/brace noted in place. On 3/4/20 at 8:45 AM and on 3/5/20 at 8:30 AM, Resident #109 was again observed in bed. There was no splint noted on both UE. On 3/4/20 at 8:50 AM, Nurse Aide (NA) # 8,	F 688	of current facility residents on 3/26/2020, to identify residents with orders for ROM and splinting. There were no other residents identified. The ADON, Unit coordinators and OT□s reviewed those identified with orders to assure ROM and splinting continued to be appropriate. The orders for splinting and ROM were removed from the Medication Administration Record (MAR), Treatment Administration Record (TAR) and the Point of Care documentation record and written on the Functional Maintenance grid form for documentation to be completed by the CNA assigned to the identified resident. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing and/or the ADON provided education on 3/26-3/27 2020, for the licensed nurses and CNA□s, regarding the Functional Maintenance program, which includes communication of the program and documentation. Newly hired licensed nurses and CNA□s will be educated during new hire orientation. When a resident has an order for a functional maintenance program, the nurse will write the order on the Functional Maintenance grid form and will communicate to the CNA regarding the program need and the CNA will document on the grid form. The ADON and/or the Unit coordinators will review all residents that are on the program monthly, to assure the program remains appropriate	

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F 688	Continued From page 25 assigned to Resident #109, was interviewed. She stated that the therapy department was responsible for splint application. NA #8 added that she didn't know if Resident #109 had an order for splint application. On 3/4/20 at 10:12 AM, the Rehabilitation (Rehab) Director was interviewed. She reported that the OT had evaluated and treated Resident #109 on 1/22/20 and discharged the resident on 1/28/20 with the recommendation for ROM exercises and splint application. The Rehab Director stated that the facility used to have a restorative aide who provides the restorative nursing such as ROM exercise and splint application but since she started working at the facility in October 2019, the facility did not have a restorative aide so nursing was responsible for the ROM exercise and the splint application. On 3/4/20 at 11:55 AM, Nurse #6, assigned to Resident #109, was interviewed. She stated that she didn't know Resident #109 was supposed to have a splint. Nurse #6 indicated that the NAs were responsible for applying the splint if ordered. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that the order for the splint application was listed on the TARs and the nurses had access to the TARs. She expected the nurses to inform the NAs of residents with orders for splint application and she expected the NAs to apply the splint as ordered. 2. Resident #25 was admitted on 1/12/15. Review of his Quarterly Minimum Data Set assessment, dated 12/17/19, indicated his intact cognition.	F 688	and make recommendations/referrals as necessary to reduce/maintain or improve function. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or the ADON will audit 10 residents weekly for 4 weeks, then 20 residents monthly for 2 months, to validate that splinting and ROM is occurring and that the CNA□s are documenting the ROM and splinting on the Functional Maintenance grid form. The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2, 2020	

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F 688	Continued From page 26	F 688		

Resident ' s diagnoses included right hand contracture and hemiplegia (paralysis of one side of the body).

Review of Resident 25 ' s plan of care, dated 12/17/19, revealed his limited physical mobility due to right hand contracture with appropriate goals and interventions, included splinting to right upper extremity.

Review of the physician ' s orders for Resident #25 revealed the order, dated 12/6/19, for splinting to right upper extremity every morning for six hours as tolerated.

Record review revealed the occupational therapy discharge summary, dated 1/18/19, indicated the recommendation for Functional Maintenance Program, to apply splint on right hand every morning for six hours as tolerated to manage contracture development. The occupational therapy staff trained the nursing staff to apply splint.

Record review of the care tracker for February 2020 revealed that Resident #25 received right hand splint applications six times, he refused it three times and did not receive the splint applications twenty times.

Review of the Treatment Administration Records (TAR) for February 2020 revealed that Resident #25 received right hand splint applications seventeen times in February 2020. Other twelve days in February 2020 were left blank for splint applications. Three times in February 2020, the TAR indicated that Resident #25 received splint applications on the days he refused it, according to care tracker report.

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F 688	Continued From page 27	F 688		

Record review of the nurses ' notes for February 2020 revealed no splint application documentation for Resident #25.

On 3/2/20 at 7:55 PM, during the observation/interview, Resident #25 was in bed, well dressed and groomed. The resident did not have splint on his right hand at the time of observation. The resident indicated that he did not receive splint today.

On 3/3/20 at 8:55 AM, during the observation/interview, Resident #25 was in his bed. He had right hand splint applied. The resident indicated that the staff applied the hand splint to his right hand not every day but often. He continued that he could tolerate it for 4-6 hours and the staff would take it off.

On 3/3/20 at 9:45 AM, during an interview, Nurse #3 indicated that Resident #25 had right hand contracture and received splint to right hand. The nurse aides were responsible for splint application in the morning and splint removal in six hours. The nurses documented right splint application in the TAR. Nurse #3 stated when she worked with Resident #25, she always checked if the resident received his right-hand splint.

On 3/4/20 at 2:10 PM, during an interview, Rehabilitation Director indicated that Resident #25 received occupational therapy for right hand contracture, including splinting, and was discharged to Functional Maintenance Program on 1/18/19. The therapy staff trained the floor nurse aides to perform range of motion in preparation to splint application, to apply the splint on his right hand for six hours daily and

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F 688	Continued From page 28 check the skin before and after the procedure. On 3/4/20 at 2:30 PM, during an interview, Nurse Aide #1 indicated that she assigned to work with Resident #25 this shift and was not aware of his splint application requirements. Nurse Aide #1 explained that she did not check Kardex at the beginning of the shift and missed the splint application for Resident #25. On 3/4/20 at 2:50 PM, during an interview, Assistant Director of Nursing (ADON) indicated that the facility did not have restorative program. The therapy department discharged residents to the Functional Maintenance Program and trained the nurse aides to continue correct splint application regiment. The nurse aides could check the Kardex and clarify splint application with the nursed. The nurse aide documented the splint applications in the Kardex and reported to the nurse if the resident refused it. The nurses documented splint application in the TAR. ADON could not explain the discrepancies between TAR and care tracker report in February 2020 in regard to splint application. The staff did not report any issues with splint application for Resident #25. On 3/4/20 at 3:10 PM, during an interview, the Administrator expected the staff to follow the orders and plan of care for splint application, document it appropriately in the Kardex and TAR.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		4/2/20

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F 692	Continued From page 29 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide therapeutic diet (thickened liquids) as ordered to 1 of 5 sampled residents reviewed for nutrition (Resident #19). Findings included: Resident #19 was admitted to the facility on 12/4/19 with multiple diagnoses including glaucoma. The modification admission Minimum Data Set (MDS) assessment dated 12/16/19 revealed that Resident #19 was not on therapeutic diet. Resident #19 had a doctor's order dated 12/4/19 for mechanical soft diet with thin liquids. On 1/18/20, there was a doctor's order to change Resident #19's diet to mechanical soft with nectar	F 692	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) provided education on March 4, 2020 for the licensed nurses and nursing assistants regarding following physician orders and tray card orders, for therapeutic diet and liquid consistency. Resident #19 remains on a Regular mechanical soft diet with nectar thick liquids. Resident #19 was observed following ingestion of thin liquids on 3/4/20, with no negative side effects. Address how the facility will identify other residents having the potential to be	

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F 692	Continued From page 30 thick liquids. Resident #19 did not have a care plan developed for nutrition. On 3/4/20 at 8:45 AM, Resident #19 was observed up in wheelchair in her room. Nurse #6 was observed to offer the resident a cup of thin water to drink. After drinking from the cup, Resident #19 was observed to start coughing. On 3/4/20 at 8:50 AM, Nurse #6 was interviewed. She stated that she did not know that Resident #19 was on thickened liquids. Nurse #6 reviewed the electronic doctor's orders and verified that Resident #19 was supposed to have nectar thick liquids. On 3/4/20 at 8:51 AM, Resident #19 was observed up in wheelchair in her room. Her breakfast tray was observed in front of her. The tray contained a glass with thin orange juice. The dietary card revealed mechanical soft diet with nectar thick liquids. Nurse Aide (NA) # 9 was at the resident's bedside ready to feed the resident. On 3/4/20 at 8:52 AM, NA #9 was interviewed. The NA stated that she did not know that Resident #19 was on thickened liquids. NA #9 read the dietary card and stated that the resident was supposed to have nectar thick liquids. At 8:53 PM, Nurse #6 was observed to remove the thin orange juice from the resident's tray. On 3/4/20 at 12:00 Noon, the Dietary Manager (DM) was interviewed. He stated that nursing staff were responsible for providing liquids to the resident's trays prior to serving the trays to residents every meal. The dietary department had	F 692	affected by the same deficient practice; The Unit Managers identified current facility residents with physician orders for a therapeutic/mechanically altered diet and/or thickened liquids on March 4, 2020. The ADON and/or Unit Managers provided education beginning on March 4, 2020 for the licensed nurses and nursing assistants regarding following physician orders for therapeutic/mechanically altered diet and thickened liquids. Licensed nurses and nursing assistants will read the tray card or Medication Administration record (MAR) to identify residents that require thickened liquids prior to providing liquids to the resident. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The ADON and/or Unit Managers provided education beginning on March 4, 2020, for the licensed nurses and nursing assistants regarding following physician orders for therapeutic/mechanically altered diet and thickened liquids. Licensed nurses and nursing assistants will read the tray card or Medication Administration record (MAR) to identify residents that require thickened liquids prior to providing liquids to the resident. Newly hired nursing staff will be educated during new hire orientation. The physician will provide a diet order that consists of the type of diet, and consistency of food and liquids. The	

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F 692	Continued From page 31 to provide the beverages (pitchers with juice, water, tea, coffee) on the cart and the nursing staff poured the beverage for each resident. The thickened liquids were kept in the cooler at each resident's rooms with order for thickened liquids and in the nourishment refrigerators on each hall. On 3/5/20 at 8:20 AM, the NAs (NAs #8 & #9) were observed passing the breakfast trays. The breakfast cart was observed to have pitchers of regular juices, water and coffee. The NAs were observed to pour beverage to the glass prior to serving the tray to each resident. There was no NA observed reading the dietary card prior to serving the beverages. On 3/5/20 at 8:30 AM, NAs #8 and #9 were interviewed. They both stated that they gave and received verbal reports between shift and they were not informed that Resident #19 was on nectar thick liquids. They also reported that they had not been reading the dietary cards for each resident. On 3/5/20 at 8:35 AM, Nurse # 6 was interviewed. She stated that nurses gave and received verbal report from shift to shift and she was not informed that Resident #19 was on nectar thick liquids. Nurse #6 reported that resident's diet was not listed on the MAR. On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. She expected the nursing staff to read the dietary card prior to serving the trays to residents.	F 692	order will be communicated to the dietary manager and will be input into the tray card system. The order will also appear on the MAR, at the top of the page. Licensed nurses and nursing assistants will view the tray card and/or the MAR to validate meal and liquid order prior to providing liquids to the resident. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON and/or the Unit managers will review physician telephone orders 5 x week for 4 weeks, then 3 x week for 2 months, to validate diet orders were transcribed onto the MAR and orders were reflected correctly on the dietary tray card. The DON, ADON and/or the Unit managers will observe meal pass or medication pass 5 x week for 4 weeks then 3 times a week for 2 months to validate that nursing staff are providing the correct liquids as ordered. The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2, 2020	

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F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		4/2/20

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F 732	Continued From page 33 by: Based on record review and staff interview, the facility failed to post the nurse staffing information accurately in the area of Registered Nurse (RN) coverage for 13 of 60 days reviewed. Findings included: The daily nurse staffing information posting and the schedule were reviewed for January and February 2020. The posting and the schedule were reviewed with the Assistant Director of Nursing (ADON) and the following inaccuracies were noted: January 1 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 2 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 3 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 18 - 2 RN coverage on the posting, the schedule had 1 RN coverage - Nurse #8 January 19 - 1 RN coverage on the posting, the schedule had no RN coverage January 23 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) January 26 - 2 RN coverage on the posting - the schedule had 1 RN coverage - (ADON) January 30 - no RN coverage on the posting, the schedule had 1 RN coverage - (ADON) February 1 - no RN coverage on the posting, the schedule had 1 RN coverage - Nurse #9 February 2 - no RN coverage on the posting, the schedule had 1 RN coverage - Nurse #9 February 8 - 2 RN coverage on the posting, the schedule had 1 RN coverage - Nurse #10 February 9 - 2 RN coverage on the posting, the schedule had no RN coverage	F 732	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Administrator and the Scheduler corrected the Posted Nurse Staffing Information to reflect the accurate RN hours for each day identified, 1/1,1/2,1/3,1/18, 1/19, 1/23, 1/26, 1/30, 2/1, 2/2, 2/8, 2/9, and 2/15. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; No residents have been affected by the alleged deficient practice. The scheduler completed and audit of the Posted Nurse Staffing information from December 1,2019- March 13, 2020. No other dates were identified requiring correction. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator provided education on 3/25/2020, for the Scheduler and the ADON regarding posting of accurate nursing hours on the Posted Nurse Staffing Information form. The Scheduler will document the scheduled nursing hours on the Nurse Staffing form daily, and will update the form if staffing hours change. The forms will be maintained in the Scheduler□s office for at least 18 months.	

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F 732	Continued From page 34 February 15- no RN coverage on the posting, the schedule had 1 RN coverage - Nurse #11 On 3/5/20 at 11:50 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was responsible for completing the daily nurse staffing information sheet Monday through Friday and the weekend supervisor was responsible Saturday and Sunday. The ADON further reported that at times she did not have time to complete the staffing information sheet, so the scheduler did it for her. She indicated that she did not know why the posting and the schedule did not match. On 3/5/20 at 4:15 PM, the Scheduler was interviewed. She revealed that the ADON was responsible for completing the staffing information however at times she was busy, so she did it for her. She acknowledged that the daily staffing information was not completed accurately for the RN coverage. She did not know that the ADON could be counted as RN coverage and she did not know some nurses were RNs and not License Practical Nurses (LPNs). On 3/5/20 at 4:16 PM, the ADON was interviewed. She stated that she expected the daily staffing information posting to be accurate.	F 732	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the DON will review the Nurse staffing form 5 x week for 4 weeks then 3 x week for 2 months, to validate that nursing hours are accurately documented on the form. The Administrator and/ or the DON will review the audits monthly to identify patterns/slash trends and will adjust the plan as necessary. The Administrator and/or the DON review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2,2020	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		4/2/20

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F 761	Continued From page 35 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove one expired Nitroglycerin tablets container, one container of Loperamide Oral Suspension, one Breo Ellipta inhaler, stored in 2 of 5 medication administration carts (100 hall and 300 hall); failed to remove one expired multi-vial insulin container, stored in 1 of 3 medication storage rooms; failed to provide the date of opening for one multi-vial insulin container and two insulin pen injectors, stored in 2 of 5 medication administration carts (100 and 300 halls); failed to discard several loose pills that were identified in the medication carts draws for 3 of 5 medication administration carts (100 and 300 halls). Findings Included:	F 761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1: a) On 3/2/20, the licensed nurse disposed of the expired bottle of Nitroglycerin, the Humulin insulin pen and the loose pills found in the bottom of drawer 2 on the 300- hall back medication cart. b) On 3/2/20, the licensed nurse disposed of the loose medications that were in the bottom of the drawer 2 on the 300- hall front medication cart. c) On 3/3/20, the licensed nurse disposed of the expired container of	

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F 761	Continued From page 36 1a. On 3/2/20 at 6:40 PM, observation of the Back Medication Administration Cart on 300 hall, with Nurse #1 revealed one half empty container of Nitroglycerin, 25 tablets, expired in 10/19/19 and one opened Humulin insulin pen-injector, 100 units/ml, 3 ml, half empty with no date of opening. Review of the manufacturer ' s literature/information recommended to discard the Humulin insulin pen-injector 28 days after opening. In the second draw of the medication cart there were noted two white round shape loose pills. On 3/2/20 at 6:45 PM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to check the expiration date on containers with tablets and remove expired medications from the medication administration cart. The nurse had not checked the expiration date on container of Nitroglycerin tablets in her medication administration cart at the beginning of her shift. The nurse did not administer the expired Nitroglycerin tablets this shift. b. On 3/2/20 at 7:30 PM, observation of the Front Medication Administration Cart on 300 hall, with Nurse #2 revealed: in the second draw of the medication cart there were noted one yellow, one pink, two blue round shape loose pills, one white loose capsule; in the third draw of the medication cart there were noted one white, one blue and one pink loose pills. On 3/2/20 at 7:35 PM, during an interview, Nurse #2 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse	F 761	Loperamide, expired Breo inhaler, the two opened Lantus pens that were not dated when opened, and the loose white pill that was in the bottom of drawer 2 on the 100 hall medication cart. 2: On 3/2/20, the licensed nurse disposed of the opened multi vial of Novolog insulin dated 1/24/20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be the alleged deficient practice of failure to date/label medications and proper storage of medications. The Assistant Director of Nursing (ADON), Unit coordinators (UC)and licensed nurses (LN) completed an audit of all medication carts and medication rooms on March 9 - 13, 2020, to identify expired, undated/unlabeled medications and storage of medications. There were no other discrepancies identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The DON and ADON completed education on March 27-30, 2020 for licensed nurses regarding storage of medications, dating and labeling of medications and monitoring for expiration dates. Newly hired licensed nurses will be educated during new hire orientation. The Licensed nurses will check medication carts and medication rooms nightly to assure medications are stored	

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F 761	Continued From page 37 #2 did not clean the cart before her shift. c. On 3/3/20 at 7:40 AM, observation of the medication administration cart on 100 hall, with Nurse #3 revealed the following expired medications were found: the half empty container of Loperamide Oral Suspension, 120 ml, expired on October 2019 and Breo Ellipta inhaler, 100/25 mcg, opened on 1/5/20. Review of the manufacturer ' s literature/information recommended to discard the Breo Ellipta inhaler 42 days after opening, which would have been on 2/16/20. There were two opened Lantus insulin pen-injectors, 100 units/ml, 3 ml each, with no date of opening. Review of the manufacturer ' s literature/information recommended to discard the Lantus insulin pen-injector 28 days after opening. In the second draw of the medication cart there was noted one white round shape loose pill. On 3/3/20 at 7:45 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to mark the date of opening on the insulin pen and remove expired medications from the medication administration cart. The nurse confirmed that Lantus insulin pen-injectors were opened. The nurse had not checked the expiration date on Loperamide Oral Suspension or Breo Ellipta inhaler in her medication administration cart at the beginning of her shift. The nurse did not administer Lantus insulin pen-injections this shift. Nurse #3 could not identify one white pill in the draw but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. 2. On 3/2/20 at 7:10 PM, observation of the	F 761	properly and dated and labeled appropriately, including monitoring medications for expiration dates. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON and/or the UC□s will audit medication carts and medication rooms 5 x week for 2 weeks, then weekly for 2 months to validate that medication carts and medication rooms are free of loose medications, medications are properly stored, dated and labeled, and medications are not expired. The DON and/or the ADON will review the audits to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue according to the discretion of the QAPI committee. Indicate dates when corrective action will be completed; April 2,2020	

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F 761	Continued From page 38 medication storage room on 300 hall with Nurse #1 revealed in refrigerator one multi vial container of Novolog (insulin), 100 units/ml, 10 ml, half-empty, opened on 1/24/20. Review of the manufacturer ' s literature/information recommended to discard the Novolog insulin multi vial container 28 days after opening, which would have been on 2/21/20. On 3/2/20 at 7:15 PM, during an interview, Nurse #1 indicated that all the nurses were responsible to check and remove the expired medications from the medication storage room. Nurse #1 did not check the refrigerator in the medication storage room during her shift. On 3/3/20 at 10:55 AM, during an interview, the Assistant Director of Nursing indicated that all the nurses were responsible to put date of opening on insulin pens-injectors and multi vial containers, check all the medications in medication administration carts/medication storage rooms for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.	F 761		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		4/2/20

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F 947	Continued From page 39 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a required dementia management training for 4 of 5 nurse aides (NA) reviewed for required annual training. (NA # 2, # 3, #4 and #5). The findings included: Review of the employee file revealed NA #3 was hired on 8/16/19 and NA #5 was hired on 12/11/2019. Review of the in-service training information of NA #3 and NA #5 indicated they did not receive any dementia in-service training since their hire dates. During an interview on 3/2/20 at 7:33 PM, NA #3 stated she had not received any dementia training since she was hired or during orientation. During a telephone Interview on 3/3/20 at 11:48 AM, NA #5 stated she had not received any dementia training since she was hired or during orientation. Review of the employee file revealed NA #2 hire date was 9/30/97. NA #4 hire date was 5/19/17. Review of the training information revealed NA #2	F 947	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Assistant Director of Nursing and Nurse Supervisor provided Dementia Training using The Hand in Hand Modules from the CMS website between March 13 and March 17, 2020 for all nursing staff. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents with dementia have the potential to be affected by the alleged deficient practice of failure to provide dementia management training. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Assistant Director of Nursing and nurse supervisor provided Dementia management training using the Hand in	

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F 947	Continued From page 40 did not receive dementia training during the period of 9/30/2018 through 9/30/2019. NA #4 did not receive dementia training during the training period of 5/19/2018 through 5/19/2019. The employee file did not have an in-service or training record indicating when NA #3 or NA #4 had been last trained on dementia management. During an interview on 3/2/20 at 7:08 PM, NA #4 stated she had not received dementia training in the past year. NA #4 further stated she had some dementia training when hired. NA#4 indicated she could not remember the last time she was trained on dementia management. During an interview on 3/2/20 at 8:00 PM, NA #2 stated she had not received dementia training in the past year. NA #2 added she had not received any in-service or dementia training in more than a year. Interview was conducted on 3/4/20 at 3:30 PM, with the Assistant Director of Nursing (ADON) who was responsible for training, stated she was responsible for training and keeping up a file for each nurse aide. The ADON stated all employees were required to receive dementia training during orientation and annually. The ADON reviewed the annual in-service records and the employee files of the 4 identified nurse aides. The ADON confirmed the required dementia training for new hires and the annual dementia training had not been done. Interview was conducted on 3/4/20 at 4:01 PM, with the Administrator who stated all employees should be trained on dementia upon hire. The nurse aides should receive training during orientation and annually. The Administrator	F 947	Hand modules from the CMS website on 3/30, 3/31/ & 4/1, 2020, for current facility staff. Newly hired staff will receive training during new hire orientation. Dementia Management training will be provided annually for all current staff. The HR manager will keep a Dementia Training log of current facility staff, to assure all staff receive annual Dementia management training. Dementia Management training will be offered at a minimum of q 6 months, to assure all staff have the opportunity to attend the required training. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the HR director will audit new hire orientation packets weekly for 4 weeks then monthly for 2 months to validate that Dementia Management training was provided during new hire orientation. The HR director will maintain a Dementia Training log to include all current staff members, to assure all staff members attend the required annual Dementia management training. The Administrator and or HR Director will review the audits monthly to identify patterns/slash trend and adjust the plan as necessary to maintain compliance. The administrator and/or the HR Director will review the plan during monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will	

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F 947	Continued From page 41 reviewed the most recent dementia training on 1/9/20 and confirmed the identified nurse aides as well as other staff had not been trained annually on dementia. Administrator stated the ADON was expected to follow-up and ensure all employees training records were updated and maintained.	F 947	be completed; April 2, 2020	